

## **Luray Family Dental** **Financial Policy**

Welcome! Thank you for choosing us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

### **FINANCIAL AGREEMENT:**

Patients are expected to pay for services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of treatment of their estimated co-pay and deductible at the time of service. Your estimated co-pay for treatment, which is the amount not covered by your insurance, is due at the time of treatment depending upon the reconciliation of the insurance payment.

Payments may be made using cash, visa, MasterCard, flex spending cards, American Express, and/or Discover. **PERSONAL CHECKS ARE NOT ACCEPTED.** We also offer CARECREDIT, a financing option that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance. There will be a \$25 late fee charge after 30 days. Accounts over 90 days are subject to our collection agency.

There will be a fee for any additional procedure NOT included in the original treatment plan.

For minor patients, the responsible party for the account **MUST BE PRESENT.** If the minor has insurance through a person not present, we will inform you of the information required by our office to bill the insurance company, **WE WILL NOT BILL A THIRD PARTY THAT IS NOT PRESENT TO SIGN THIS FINANCIAL POLICY.**

### **APPOINTMENTS:**

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least a 24-hour notice for any cancelled appointment. There is a \$50 fee per hour for missed appointments, waived the first time. After 3 missed appointments or cancelled appointments we will not reserve an appointment for you. We will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours.

### **INSURANCE INFORMATION:**

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance may not run January-December). If your insurance plan changes please let us know as soon as possible.

## Luray Family Dental

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**OUR DENTISTS WILL DIAGNOSE TREATMENT BASED ON YOUR DENTAL HEALTH, NOT YOUR INSURANCE COVERAGE.**

**YOU MUST REALIZE THAT:**

Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by buys an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for tooth that has extensive decay; however, the dental plan may only cover the cost of filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.

**Participating Insurance:** As a participating insurance provider, we will estimate your copayment and file insurance claims for treatment. Your **estimated copayment is due at the time of service**. Your insurance company will processes and finalize the claim once they receive it, in some instances resulting in a credit or balance. We will contact you regarding any credit and reimburse you, or you may choose to keep the credit on your account for future treatment. A bill will be mailed for any remaining balances; Financial Agreement applies, please refer back to that section.

**Non-participating Insurance:** The courtesy explained above is extended to you. **Your estimated copayment is due at the time of service.** If your insurance company has not paid within 90 days of services rendered, you will need to make full payment to this office and be reimbursed when your insurance company pays. Any treatment you receive that is not covered by your insurance plan for any reason is your responsibility. Financial Agreement applies.

**Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the financial policy also shall cover your dependent children who are patients of the practice.**

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**Patient(s) name PLEASE PRINT**

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**Responsible party signature (&PRINT if other patient)**

**Date**

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**Date of Birth of Responsible party**

**SSN of Responsible party**